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Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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Dr. Alice Rivlin
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The Brookings Institution
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Washington, D.C. 20036

Dear Dr. Rivlin:

Thank you for appearing before the Subcommittee on Health on Wednesday, January 21, 2015, to testify at the hearing entitled "A Permanent Solution to the SGR: The Time is Now."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Friday, March 13, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. In 2012, MedPAC recommended fee-for-service benefit reforms that would replace the current benefit design and would include reforms similar to some of those you, Senator Lieberman, and the President's Fiscal Commission recommended. However, MedPAC recommended an additional charge on Medigap insurance, rather than restricting first dollar coverage. Would you please discuss the policy trade-offs of the different approaches, and which approach you prefer and why?

2. One of the worries that some have in making changes to Medigap is that lower-income seniors could face higher cost-sharing. However, with nearly one in three beneficiaries today enrolled in a Medicare Advantage plan, do you think that the Medicare Advantage plans –which all offer full catastrophic protection—would be a viable alternative to Medigap for many of the impacted beneficiaries?

3. In your testimony you said "SGR reform must not add to future deficits. Cost growth in health care has slowed in recent years, which makes projected health care spending appear less daunting than it has in the past……Fixing the SGR must be paid for – that's just good budgeting." Would you please explain why it's good policy to offset the SGR bill and why that's important for the budget and for beneficiaries?

4. According to the Congressional Budget Office, Medicare's spending will continue to climb over the coming decade—totaling more than $1 trillion in 2024. One of my worries is that as Medicare consumes more general revenue dollars, it will crowd out other domestic policy discretionary priorities. What Medicare reforms do you think could be adopted with the SGR that would help put downward pressure on Medicare spending the most?

5. I am sure you are familiar with some research by the Urban Institute which finds that, each Medicare beneficiary will, on the average, take almost three times more out in Medicare benefits than they put in to the system in payroll taxes and premiums. One of the facts that demonstrates this is that individuals' payroll taxes do not "pay for" the full cost of their benefits. Please explain why that mathematical reality itself necessitates changes to Medicare over time?

6. It has been suggested that the only thing Congress need to do to fix Medicare's funding shortfall is raise general taxes. You mentioned you're in favor of more revenue *in the context of tax reform* that broadens the base and lowers rates. Can you talk about any concerns you have from a policy perspective regarding just increasing taxes to pay for the SGR? For example, would it fix the problems of seniors not having catastrophic protections or millionaires still having their premiums paid for by taxpayers? Based on your years of experience working with Congress to

examine Medicare and federal programs, do you think the general public would accept a large tax hike to pay for Medicare changes?

7. It can be said that SGR reform is Medicare reform rather than a "physician payment bill," because the threat of not fixing it falls squarely on the shoulders of seniors who might have access to their doctor interrupted if we fail to reform. Do you agree with that perspective and, if so, can you provide a few thoughts on how SGR reform is Medicare reform?

8. The SGR reform act is authored by Dr. Burgess and supported by many members of both sides of the aisle – including the chairman and ranking members of the Energy and Commerce, Ways and Means, and Senate Finance Committees. This bill puts forward a new vision for how physicians might deliver services and be paid under the Medicare program. Your testimony includes some thoughts on the policy, but I am curious as to whether you think the provisions in the bill have the potential to help increase the quality and delivery of care to seniors in need?

9. There has been a lot of discussion in recent years about the slowdown in the annual growth rate of Medicare spending. You have probably been following the literature and CBO's analysis pretty closely, but my question is pretty simple: in your opinion, is the slow-down in Medicare spending a reason not to offset SGR reform? And, based on your historical perspective, do you think it is likely to rebound in coming years closer to historical averages?

10. As a former director of the Congressional Budget Office, you understand well the way that the current SGR formula creates uncertainty in the federal budget. Please discuss why, from a CBO perspective, it could actually cost more to do annual short-term patches, rather than adopting a long-term SGR reform proposal? And is it accurate to say that CBO's estimate of the cost of SGR repeal is "on sale" now compared to historical averages? Do you expect the cost of SGR repeal to increase in the future?

The Honorable Larry Bucshon, M.D.

1. In your testimony you support MedPAC's recommendation to increase branded medication co-pays and decreasing generic medication co-pays for the Part D LIS population During questioning at the hearing you also stated that this policy would not have a negative impact on Part D LIS beneficiaries. We have 200,275 Part D LIS beneficiaries in Indiana who take a mix of doctor prescribed branded and generic medications to control their multiple conditions. I have seen data (highlighted below) that challenges your assertion and I would like your feedback. Faced with greater cost-sharing, low-income individuals may attempt to switch to less costly but less effective or tolerable therapies or may entirely forego, delay, or decrease use of recommended medications. For example, research has shown that responsiveness to price increases for prescription drugs is significantly greater than for emergency room (ER) and hospital visits among low-income populations.xx Comprehensive drug coverage improves medication adherence, and reduces racial disparities in outcomes and costs. A recent Health Affairs study found that when cost-sharing for cardiovascular drugs was eliminated following a heart attack, total healthcare spending for nonwhite patients decreased by 70%, and rates of cardiovascular events decreased by 35%.xxi Financial disincentives to use brand medicines may unintentionally create barriers to prescription drug adherence among low-income populations,

potentially costing Medicare and Medicaid more in unnecessary hospitalizations and otherwise avoidable medical care. CBO acknowledged that policies that decrease the use of prescription medicines would cause Medicare medical spending to rise; citing a substantial body of evidence that indicates that "people respond to changes in cost sharing by changing their consumption of prescription drugs," including reductions in number of prescriptions filled in response to price increases.xxii. Other researchers found that even small copay increases for low-income cancer patients in Medicaid reduced their use of necessary medicines while significantly increasing the probability of having an ER visit and raising their health care costs.xxiii

a. If you could please provide you thoughts on this data, I would greatly appreciate it.